HEALTH AND WELFARE AGENCY — DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

CALIFORNIA ALCOHOL AND DRUG DATA SYSTEM (CADDS) — PARTICIPANT RECORD (PR)

(USE BALL POINT PEN—PRESS HARD)

1. PROVIDER ID — Program | County | Facility ID
2. FORM SERIAL NUMBER
3. UNIQUE PARTICIPANT ID — Initials (Last-First) | Sex (1-Male 2-Female) | Date of Birth (Month Day Year)
4. PROVIDER'S PARTICIPANT ID (Optional)
5. CODEPENDENT/SIGNIFICANT OTHER ..... (1-Yes 2-No) **2**
   (If yes, complete Items 1–15; answer yes if receiving services because of **someone else's** alcohol/drug problem.)
6. RACE
   01. White
   02. Black/African-American
   03. American Indian
   04. Alaskan Native
   05. Asian Indian
   06. Cambodian
   07. Chinese
   08. Filipino
   09. Guamanian
   10. Hawaiian
   11. Japanese
   12. Korean
   13. Laotian
   14. Samoan
   15. Vietnamese
   16. Other Asian
   17. Other Race
7. ETHNICITY
   1. Not Hispanic
   2. Mexican/Mexican American
   3. Cuban
   4. Puerto Rican
   5. Other Hispanic/Latino
8. EMPLOYMENT STATUS
   1. Employed Full Time (35 or more hours/week)
   2. Employed Part Time (less than 35 hours/week)
   3. Unemployed (looking for work)
   4. Not in the labor force (not seeking employment)
9. HIGHEST SCHOOL GRADE COMPLETED ..... (00-20, GED-12)
10. PRINCIPAL SOURCE OF REFERRAL
    1. Individual (Includes self-referral)
    2. Alcohol/Drug Abuse Care Program
    3. Other Health Care Provider
    4. School (Educational)
    5. Employer/EAP
    6. Non-SACPA: Court/Criminal Justice
    7. 12 Step mutual aid (AA, Al-Anon, etc.)
    8. Other Community Referral
    9. SACPA Court/Probation
    10. SACPA Parole
11. IS THIS PERSON CURRENTLY PREGNANT? ..... (1-Yes 2-No)
    Answer for ALL participants. (If this participant, whether pregnant or not, is in a Perinatal Services Network Program, complete boxes 14–16 of Coded Remarks. Refer to current Coded Remarks instructions.)
12. LEGAL STATUS
    1. Not applicable
    *2. Under parole supervision by CDC
    3. On parole from any other jurisdiction
    4. On probation from any federal, state or local jurisdiction
    5. Admitted under diversion from any court
    6. Incarcerated
    *If participating in a Parolee Services Network or Female Offender Treatment project, enter participant's CDC number in boxes 1–6 of Coded Remarks.
13. DISABILITY IMPAIRMENT (1st, 2nd, 3rd)
    (Enter the codes for up to three impairments; if no impairment, enter "1".)
    1. **NONE**
    2. Visual
    3. Hearing
    4. Speech
    5. Mobility
    6. Mental
    7. Developmentally Disabled
    8. Other
14. DATE OF ADMISSION ..... (First face-to-face treatment/recovery service) Month Day Year
15. TRANSACTION TYPE ..... 1-Initial Admission; 2-Transfer or change in service
16. TYPE OF SERVICE
    Non-residential/Outpatient:
    1. Treatment/recovery
    2. Day program–intensive
    3. Detoxification
    Residential:
    4. Detoxification (hospital)
    5. Detoxification (non-hospital)
    6. Treatment/recovery (30 days or less)
    7. Treatment/recovery (31 days or more)

STOP HERE if Codependent (Item 5) is Yes (1).

17. MEDICATION PRESCRIBED
    1. None
    2. Methadone and/or LAAM
    3. Other
18. NUMBER OF PRIOR EPISODES IN ANY ALCOHOL OR DRUG TREATMENT/RECOVERY PROGRAM ..... (ENTER 0–9)

CODES: (PLACE ANSWERS IN MATRIX BELOW FOR QUESTIONS 19–21)

ALCOHOL/DRUG PROBLEM (Enter code in Question 19 below; "00" is not a valid response.)
01. Heroin
02. Alcohol
03. Barbiturates
04. Other Sedatives or Hypnotics
05. Methamphetamine
06. Other Amphetamines
07. Other Stimulants
08. Cocaine/Crack
09. Marijuana/Hashish
10. PCP
11. Other Hallucinogens
12. Tranquilizers (Benzodiazepine)
13. Other Tranquilizers
14. Non-Prescription Methadone
15. Other Opiates and Synthetics
16. Inhalants
17. Over-The-Counter
21. Other (specify) _____
22. **NONE**

USUAL ROUTE OF ADMINISTRATION (Enter code in Question 20 below)
1. Oral 2. Smoking 3. Inhalation 4. Injection (IV or intramuscular) 5. Other

FREQUENCY OF USE (Enter code in Question 21 below)
1. No past month use
2. 1–3 times in past month
3. 1–2 times per week
4. 3–6 times per week
5. Daily

Question #	Primary	Secondary	Tertiary
19. ALCOHOL/DRUG PROBLEM			
20. USUAL ROUTE OF ADMINISTRATION			
21. FREQUENCY OF USE			
22. AGE OF FIRST USE/ ALCOHOL INTOXICATION			

Instructions
- Age of First Use—Primary must be at least 5 years old.
- If Secondary Alcohol/Drug Problem is NONE (22), leave Secondary Route, Frequency, and Age blank.

23. HAS THIS PARTICIPANT USED NEEDLES DURING THE PAST TWELVE MONTHS? ..... (1-Yes 2-No)
24. SPECIAL SERVICES/CONTRACT: .....
    (Leave blank unless number is assigned by ADP.)

DISCHARGE INFORMATION

28. DATE OF DISCHARGE ..... (Last face-to-face treatment/recovery service) Month Day Year
29. DISCHARGE STATUS
    1 - Completed Treatment/Recovery Plan, Goals
    2 - Left Before Completion - with Satisfactory Progress
    3 - Left Before Completion - with Unsatisfactory Progress
    4 - Referred or Transferred for Further Drug/Alcohol Treatment/Recovery
30. EMPLOYMENT STATUS ..... (Use codes for Item 8)
31. *ALCOHOL/DRUG PROBLEM ..... (Use codes for Item 19) — Primary | Secondary | Tertiary
    *If participating in a Perinatal Services Network Project, complete box 18 of Coded Remarks.
32. WAS THIS PARTICIPANT PREGNANT ANYTIME DURING THIS TREATMENT/RECOVERY EPISODE? ..... (1-Yes 2-No)

OPTIONAL DATA ITEMS

25. HAS THIS PARTICIPANT EVER BEEN DIAGNOSED AS ALSO HAVING CHRONIC MENTAL ILLNESS? ..... (1-Yes 2-No)
26. IS THIS PARTICIPANT HOMELESS? ..... (1-Yes 2-No)
27. ZIP CODE OF PARTICIPANT'S CURRENT RESIDENCE

CODED REMARKS: REFER TO THE CURRENT CODED REMARKS INSTRUCTIONS.

(CDC ID) 1 2 3 4 5 6 7 8 9 10 11 12 13 (PSN) 14 15 16

(MEDI-CAL) (PSN) 17 18 19 20 21 (CalWORKs) 22 23 24 25 26 27 28 29 30

31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46

DETOX ADMISSION AND DISCHARGE COPY

OSP 01 56257